

Surgical Associates of Central New Jersey

PATIENT INFORMATION

Name: _____ **Sex:** Male Female
LAST FIRST MI

Address: _____ **Birth Date:** ____/____/____
STREET / P.O. BOX

Home # (____) - _____ **SS#** ____ - ____ - ____
CITY STATE ZIP CODE O.K. to leave a detailed message? Y N

Work # (____) - _____ O.K. to leave a detailed message? Y N

Cell / Pager # (____) - _____ O.K. to leave a detailed message? Y N

Referred By: _____ **Referrer's Phone#** (____) - _____

Family Doctor: _____ **Family Doctor's Phone#** (____) - _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy#:** _____ **Group#:** _____

Insured's Name: _____ **Insured SS#:** ____ - ____ - ____

Insured's Relationship To Patient: Self Spouse Parent Other **Insured's Date of Birth:** ____/____/____

Secondary Insurance: _____ **Policy#:** _____ **Group#:** _____

Insured's Name: _____ **Insured SS#:** ____ - ____ - ____

Insured's Relationship To Patient: Self Spouse Parent Other **Insured's Date of Birth:** ____/____/____

OTHER INFORMATION

List any people that you give our staff / doctors permission to speak with regarding your medical condition (i.e. spouse, children, siblings etc.)

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

CONSENT FOR TREATMENT / RELEASE OF INFORMATION / ASSIGNMENT OF INSURANCE BENEFITS

I consent to the use or disclosure of my protected health information (PHI) by Surgical Associates of Central NJ for the purpose of diagnosing or providing medical treatment to me, obtaining payment for my health care bills or to conduct other health care operations. I also give permission for Surgical Associates of Central NJ to receive any of my PHI from another physician or healthcare facility for the same purpose. I authorize payment of medical benefits directly to Surgical Associates of Central NJ.

Signature: _____ Date: _____